

PALO VERDE UNIFIED SCHOOL DISTRICT

California Public Employment Relations Board

Palo Verde Teachers Association, CTA/NEA, Charging Party, v. Palo Verde Unified School District, Respondent.

Docket No. LA-CE-1306

Order No. 321

June 20, 1983

Before Jaeger, Morgenstern and Burt, Members

Unilateral Change -- Health Insurance Carrier -- Increase In Benefits -- -- 09.642, 43.131, 72.661, 72.666 Regardless of whether employees' health insurance benefits increased or decreased as result of school district's changing insurance carriers, change in carriers had material and significant impact on terms and conditions of employment and was negotiable. District's claim that union waived right to bargain concerning change in carriers was rejected because, although prior contract expressly reserved to district right to change carriers unilaterally, current contract contained no clear and unmistakable waiver by union of its right to bargain concerning identity of insurance carrier. Accordingly, by changing carriers without negotiations, district violated its duty to bargain in good faith.

APPEARANCES:

Ronald C. Ruud, Attorney (Atkinson, Andelson, Loya, Ruud and Romo) for Palo Verde Unified School District.

DECISION

BURT, Member: This case is before the Public Employment Relations Board (PERB or Board) on exceptions filed by Palo Verde Unified School District (District) to a proposed decision by an administrative law judge (ALJ) finding that it violated subsections 3543.5(a), (b) and (c) of the Educational Employment Relations Act (EERA)¹ by unilaterally changing the identity of the health insurance benefit carrier for its certificated employees.

In so ruling, the ALJ upheld the central allegations filed by the Palo Verde Teachers Association, CTA/NEA (Association), while dismissing the subsection 3543.5(e) allegation. The Association filed no exceptions.

We have considered the exceptions of the District in light of the record as a whole, and hereby affirm the ALJ's proposed decision, attached hereto and incorporated by reference herein, for the reasons set forth *infra*.

FACTS

We have examined the ALJ's factual findings in light of the District's exceptions and find them free of prejudicial error. The pertinent facts may be summarized as follows:

The Association is the exclusive representative of the District's certificated work force.

The District and Association negotiated three successive agreements regarding health plans for certificated employees prior to the unilateral change herein. The 1977-78 contract provided that the District would pay health care premiums up to a fixed dollar amount, and further that " . . . the District shall retain the right to select the insurance carrier." In the subsequent agreement,

covering the period from July 1, 1978 through June 30, 1979, the language regarding health care benefits was altered, providing in pertinent part as follows:

Article 14. Salary and Benefits

2. During the term of this agreement the District will make the following contributions toward the payment of premiums for group medical, dental and vision insurance plans:

a. Up to \$104.34 tenthly for Blue Cross family coverage.

Thus, the District no longer retained the right to unilaterally select the health insurance carrier. In March 1979, the parties began negotiations for a successor agreement. On June 5, 1979, they agreed to essentially "roll over" the 1978-79 contract, with the understanding that when updated insurance cost data became available they would negotiate regarding the District's level of contribution and other matters relating to benefits.

On September 19, 1979, the parties concluded reopened negotiations regarding health benefits. The language which was ultimately agreed-upon is as follows:

1. Amend Article XIV section 14.2 to read: Effective for the 1979-80 school year, the District agrees to pay the full payment of premiums for group medical, dental and vision insurance plans without reduction of benefits.
2. The Association agrees to continue in an advisory capacity, the cooperative study of alternative health benefit plans in an effort to reduce the total premium cost of the package without a reduction in benefits.
3. The Association agrees to consider an increase in the deductible (sic) for the family health plan from \$50.00 to \$100.00 deductible for the 1980-81 school year in the event that a lower premium package is not available.

The District presented that language as its initial proposal. The Association requested that the name "Blue Cross" be specifically included as the carrier, as it had been in the prior contract, and the District refused. Superintendent Roberts, who was acting at the time as the head of the District's negotiating team, expressly testified that he did not consider the deletion of the specific designation of Blue Cross from the earlier provision to be a quid pro quo for the District's assumption of the total health plan cost.

In the late summer and fall of 1980, negotiations were held regarding a successor agreement. The District initially proposed that the health plan carrier be changed to Blue Shield. It assured the Association that the District could realize a \$15,000 savings over the next insurance year with Blue Shield, and that the benefit levels would be the same or better. It informed the Association that such a change would make the \$15,000 available as a salary increase. Thus, it offered a 7-percent increase if Blue Shield would be the carrier, and a 6-percent increase if the carrier remained Blue Cross. While stating that it would like to have the Association's agreement to the change to Blue Shield, the District informed the Association that it believed that, under the language of the September 19, 1979 health care clause, it had the right to unilaterally change carriers, that the deadline for such a change would be October 31, 1980, and that it might undertake the change unilaterally should the Association not agree before that date. No express statement that it would, in fact, change carriers was ever made by the District prior to effecting the change on November 1, 1980.

In response to the District's proposal, the Association's chief negotiator, David Bates, states that he had no problem with a shift to Blue Shield as long as the Association could ascertain that the coverage was equivalent. He stated that he needed data (which the District provided), and time for an Association consultant to review it. He also alluded to having heard of problems with Blue

Shield in another Southern California district, which gave him cause for concern.

Bates' comments were made in the context of negotiations for an entire agreement. Neither a complete collective bargaining agreement, nor any specific side agreement regarding health plans was reached prior to November 1, 1980, on which date the District unilaterally changed health insurance carriers from Blue Cross to Blue Shield.

The District concedes that it unilaterally switched from Blue Cross to Blue Shield.

In all respects the benefit levels under Blue Shield are at least as high as and, in some respects, substantially higher than those provided by Blue Cross. The uncontroverted testimony of the District's witness, Norm Shaman, established that Blue Shield coverage was substantially superior in several areas.

Blue Shield paid 100 percent of the daily room rate for a double room in a hospital or skilled nursing facility, as opposed to Blue Cross which paid only the three-bed rate. Further, Blue Shield paid such rate as well as miscellaneous hospital expenses and ICU benefits in any hospital, while Blue Cross covered 100 percent of such costs only in a contracting hospital. If care were delivered in a non-contracting hospital, the upward limit of Blue Cross coverage would be 75 percent of the rate in a contracting hospital.

The basic surgical coverage was better under Blue Shield, as was the coverage for doctors' visits to a skilled nursing care facility, consulting physician care while hospitalized, psychiatric care, ambulance, and additional accident benefits, such as physical therapy, diagnostic services such as x-rays and lab work, and dental care.

Major medical policy limits increased from \$300,000 lifetime per insured under Blue Cross to \$1,300,000 under Blue Shield.

Blue Cross paid 80 percent of customary, reasonable covered expenses up to \$4,000 per year, after which it paid 100 percent. Blue Shield paid 80 percent up to \$1,600 per year, and 100 percent thereafter.

DISCUSSION

As noted above, there is no dispute over the fact that the District unilaterally changed health insurance carriers on November 1, 1980. Further, there is no dispute regarding the well-established principle that health benefits are within the scope of representation under EERA.² PERB has expressly held that a change in health plan carriers which affects benefits received by employees must be negotiated. *Oakland Unified School District* (4/23/80) PERB Decision No. 126, aff'd *Oakland Unified School District v. PERB* (1981) 120 Cal.App.3d 1007 [175 Cal.Rptr. 105].³

In affirming PERB's *Oakland* decision, the Court of Appeals held that where a change in carriers has a material and significant effect or impact upon terms and conditions of employment, it is negotiable.

The District argues that the change in carriers from Blue Cross to Blue Shield resulted in coverage changes which were *de minimis*, and therefore did not amount to a "change" in the collective negotiating sense. The District's argument that the effect on health benefits was *de minimis* must be rejected on these facts.

First, it is clear from the far-reaching improvements in coverage levels noted above that the change to Blue Shield resulted in a substantial and material change in benefits.

The District argues that *Oakland* is distinguishable because there the change amounted to a *decrease* in benefits, whereas the instant case involves an *increase*. While we agree that there is a factual difference between the cases, we disagree that the rule established in *Oakland* turns upon whether the change in benefit levels is an increase or a decrease. Rather, *Oakland* stands for the proposition that as long as the change in carriers materially and substantially affects health benefits it cannot be undertaken unilaterally.

The District cites no case for the dubious proposition that an employer is free to unilaterally increase benefit levels. Such a holding would enable employers to, in effect, communicate to employees the lack of necessity for their support for an employee organization. Employers are no more free to unilaterally increase benefit levels than they are to decrease them. *Autoprod Inc.* (1976) 223 NLRB 773, 779. If the unilateral change regarding a matter within scope is material, it is an unfair practice.

Secondly, as the ALJ correctly points out, the specific coverage levels provided for are not the only aspects of health benefits which are negotiable. The employees have a vital interest in knowing that the terms of the health care policy will be complied with and that the promised benefits will be delivered in a timely, accurate, and efficient manner. Thus, the identity of the insurer may well be as significant as the specific benefit levels set forth in the policy. Indeed, the Association had such a concern in this case, which was not dealt with satisfactorily prior to the unilateral change.

A change to a less well-established carrier, or one which is less reliable or less able to perform, would result in a materially lower quality of health benefits for employees, even if the policies were facially identical. Under any such circumstances, a unilateral change of carrier identity would in and of itself materially affect health care benefits, and thus would violate EERA.

Waiver

The District next contends that even if the change in carriers was an unfair practice as a threshold matter, the Association waived its right to negotiate over it.

PERB, in accordance with general labor law principles, has held that waiver of the statutory right to negotiate a matter within scope must be clear and unequivocal, and will not be inferred. See, in this regard, *Amador Valley Joint Union High School District* (10/2/78) PERB Decision No. 74, 2 PERC 2192, *Davis Unified School District, et al.* (6/19/80) PERB Decision No. 116, 4 PERC 11031, *San Mateo City School District* (5/20/80) PERB Decision No. 129, 4 PERC 11092, *Solano County Community College District* (6/30/82) PERB Decision No. 219, 6 PERC 13154, *Rose Arbor Manor* (1979) 242 NLRB 795.

An example of explicit waiver of the statutory right to negotiate over a change in carriers which materially affects health benefits is contained in the 1977-78 agreement, which states that the District "... shall retain the right to select the insurance carrier." In the 1978-79 agreement, the waiver was absent, and Blue Cross was named. Additionally, a specific cap was placed upon the amount of the District's contribution for health benefits. The District argues that when the 1979 amendment was negotiated, it regained the right to select the insurance carrier unilaterally in exchange for its agreement to pay 100 percent of the insurance premium, with no dollar cap. It argues that the fact that the identity of the carrier is not specified in the 9/19/79 amendment evidences a clear and unequivocal waiver of the right to negotiate carrier identity, because it replaced language which *did* name the carrier. However, the express language of the 9/19/79 amendment does not provide such a waiver. It is silent on the carrier's identity, or on the right of either party to determine such identity. Contractual silence on a matter within scope will not be held a waiver. As the Court stated in *Oakland, supra*:

[T]he statutory right to press unfair practice claims is preserved where a subsequent contract is silent on an issue previously in dispute (*Timken Roller Bearing Company v. NLRB* (6th Cir. 1963) 325 F.2d 746 [2 A.L.R.3d 868], relying on *National Labor Relations Board v. J. H. Allison Co.* (6th Cir. 1948) 165 F.2d 766 [3 A.L.R.2d 990]).

As noted above, waiver of a statutory negotiating right will not be inferred. It is clear that the parties knew how to phrase explicit waiver language, as is evidenced by the 1977-78 clause which expressly stated that the employer retained the right to select the insurance carrier.

We further reject the District's argument that the fact that the Association initially attempted to

insert the name "Blue Cross" in the 9/19/79 amendment and subsequently withdrew that proposal constituted a waiver. The mere fact that an employee organization drops a contract proposal during the course of negotiations does not indicate that it has waived its negotiating rights thereon. *Los Angeles Community College District* (10/18/82) PERB Decision No. 252, 6 PERC 13241, citing *Beacon Piece Dyeing and Finishing Co.* (1958) 121 NLRB 1953. As we stated in *Los Angeles Community College District*, *supra*, pp. 13-14:

Where, during negotiations, a union attempts to improve upon or, as in this case, to codify the status quo in the contract and fails to do so, the status quo remains as it was before the proposal was offered. The union has lost its opportunity to codify the matter, it has failed to make the matter subject to the contract's enforcement procedures or to gain any other benefit that might have accrued to it if its effort had succeeded But the union has not relinquished its statutory right to reject a management attempt to unilaterally change the status quo without first negotiating with the union. In a sentence, by dropping its demand, the union loses what it sought to gain, but it does not thereby grant management the right to subsequently institute any unilateral change it chooses. A contrary rule would both discourage a union from making proposals and management from agreeing to any proposals made, seriously impeding the collective bargaining process.

Beacon Piece, *supra*.

The District's argument that a comparison of the language of the 1978-79 contract and the 9/19/79 amendment demonstrates that it agreed to pay 100 percent of the insurance premium in exchange for the right to unilaterally select the carrier is rejected. As noted above, the District's superintendent and chief negotiator for that contract testified expressly that the District did not propose the provision that it would pay 100 percent of the health insurance premium as a quid pro quo for an Association waiver on carrier identity.

Because neither the express contractual language of the September 19, 1979 amendment nor the testimony establishes a waiver, the Board rejects this waiver argument.

The District further argues that the Association, through its chief negotiator David Bates, expressly agreed to the switch to Blue Shield during the 1980 negotiations.

At most, the facts as summarized above establish that Bates told the District that he was not opposed to the switch so long as the Association was satisfied that existing benefit levels would be maintained. However, he also expressed concerns about Blue Shield, and made any agreement conditional upon the Association satisfying itself regarding those potential problems. The record does not reflect that such condition was satisfied prior to the unilateral change of carrier on November 1, 1980.

Even if Bates' acquiescence were not conditional, it occurred in the context of negotiations for a total agreement, which were not concluded prior to the unilateral change.

For the reasons set forth above, we find that the District failed to establish the existence of a clear and unequivocal waiver by the Association of its right to negotiate over the identity of the health plan carrier. We thus reject the District's waiver defense.

The District engaged in a unilateral change regarding a matter within scope. It thus violated subsection 3543.5(c) and, concurrently, 3543.5(a) and (b). *San Francisco Community College District* (10/12/79) PERB Decision No. 105, 3 PERC 10127.

ORDER

Upon the foregoing findings of fact, conclusions of law, and the record as a whole, and pursuant to section 3541.5(c), it is hereby ORDERED that the Palo Verde Unified School District board of trustees, superintendent, and their various agents shall:

A. CEASE AND DESIST FROM:

- (1) Failing and refusing to meet and negotiate in good faith with the Palo Verde Teachers Association, CTA/NEA, the exclusive representative of its certificated employees, by unilaterally changing the identity of the health insurance carrier for unit employees;
- (2) Denying to the Palo Verde Teachers Association, CTA/NEA rights guaranteed to it by the Educational Employment Relations Act;
- (3) Interfering with employees in their exercise of rights guaranteed to them by the Educational Employment Relations Act.

B. TAKE THE FOLLOWING AFFIRMATIVE ACTION:

- (1) No later than thirty-five (35) days after service of this Decision, prepare and post copies of the Notice to Employees attached as an appendix hereto, signed by an authorized agent of the employer. Such posting shall be maintained for at least thirty consecutive workdays at the employer's headquarters office and at all locations where notices to certificated employees are customarily posted. Such Notices must not be reduced in size, and reasonable steps shall be taken to insure that they are not defaced, altered, or covered by any material;
- (2) Written notification of the actions taken to comply with this Order shall be made to the regional director of the Public Employment Relations Board in accordance with his/her instructions.

Members Jaeger and Morgenstern joined in this Decision.

1 EERA is codified at Government Code sections 3540 *et seq.* Subsections 3543.5(a), (b), (c) and (e) provide as follows:

It shall be unlawful for a public school employer to:

(a) Impose or threaten to impose reprisals on employees, to discriminate or threaten to discriminate against employees, or otherwise to interfere with, restrain, or coerce employees because of their exercise of rights guaranteed by this chapter.

(b) Deny to employee organizations rights guaranteed to them by this chapter.

(c) Refuse or fail to meet and negotiate in good faith with an exclusive representative.

. . .

(e) Refuse to participate in good faith in the impasse procedure set forth in Article 9 (commencing with Section 3548).

2 Section 3543.2 provides, in pertinent part, as follows:

(a) The scope of representation shall be limited to matters relating to wages, hours of employment, and other terms and conditions of employment. "Terms and conditions of employment" mean health and welfare benefits as defined by Section 53200, leave, transfer and reassignment policies, safety conditions of employment, class size, procedures to be used for the evaluation of employees, organizational security pursuant to Section 3546, procedures for processing grievances pursuant to Sections 3548.5, 3548.6, 3548.7, and 3548.8, and the layoff of probationary certificated school district employees, pursuant to Section 44959.5 of the Education Code

Subsection 53200(d) defines health and welfare benefits as . . . any one or more of the following:

hospital, medical, surgical, disability, or related benefits including, but not limited to, medical, dental, life, and income protection insurance or benefits, whether provided on an insurance or a service basis . . .

3 We note that private sector cases are in accord on this issue. Thus, in *Oakland, supra*, at p. 8, fn. 7, PERB stated

In cases arising under the National Labor Relations Act (hereafter NLRA) (29 U.S.C. sec. 151 *et seq.*), courts have found that a change in the identity of the carrier or administrator of a health insurance plan is negotiable if that change affects the benefits of employees. E.g., *Keystone Consolidated Industries v. NLRB* (7th Cir. 1979) 606 F.2d 171 [102 LRRM 2664]; *Oil Workers (OCWA) v. NLRB* (D.C. Cir. 1976) 547 F.2d 575 [92 LRRM 3059]; *Connecticut Light & Power Co. v. NLRB* (2d Cir. 1973) 476 F.2d 1079 [82 LRRM 3121]; *Bastian-Blessing v. NLRB* (6th Cir. 1973) 474 F.2d 49 [82 LRRM 2689]. The Michigan Court of Appeals, following NLRA cases, found the identity of an insurance carrier to be a mandatory subject of bargaining under the Michigan Public Employment Relations Statute (Mich. Comp. Laws sec. 423.201 *et seq.*) when the identity of the carrier has an effect on the benefits. *Roseville v. Firefighters* (1974) 220 N.W.2d 147 [88 LRRM 2315].

APPEARANCES:

David William Bates for Palo Verdes Teachers Association; Ronald C. Ruud (Atkinson, Andleson, Loya, Ruud, and Romo) for Palo Verde Unified School District.

PROPOSED DECISION

PROCEDURAL HISTORY

In this case the exclusive representative charges the employer with unilaterally changing the carrier of employee health insurance. The employer contends that the identity of the carrier is not within scope because the change did not result in a loss of employee benefits. It also claims that the change was authorized by the contract or by the Association's actions.

On February 5, 1981, the Palo Verde Teachers Association, CTA/NEA (hereafter Association) filed an unfair practice charge against the Palo Verde Unified School District (hereafter District) alleging violation of Government Code section 3543.5(a),(b),(c),(d),(e) by unilaterally switching from Blue Cross to Blue Shield health insurance carrier. On February 20, 1981, the District filed a timely answer. A settlement conference was held without success. The Board issued its complaint and a formal hearing was held on April 7, 1981 at Blythe, California. At the conclusion of the hearing, the parties stipulated to place the case in abeyance until the completion of factfinding. By letter of July 20, 1981, the Association reactivated the case and proposed a briefing schedule. Upon submission of post-hearing briefs, the matter was submitted on December 15, 1982. In its closing brief, the Association withdrew the alleged violation of section 3543.5(d).

FINDING OF FACT

The Palo Verde Unified School is an employer and the Association is the exclusive representative of certificated employees within the meaning of the Education Employment Relations Act (hereafter EERA or Act).¹

Unilateral Change in Insurance Carriers - November 1, 1980

It is undisputed that the District changed its insurance carrier from Blue Cross to Blue Shield on

November 1, 1980. The change resulted in a significant improvement in health insurance benefits to employees and a \$15,000 cost saving to the District. Norm Shaman, fringe benefits advisor, testified as an expert witness comparing the Blue Cross and Blue Shield contracts. Blue Shield provided better insurance coverage in 11 benefit areas. Following the submission of several amendments to its plan Blue Shield provided no decreases from prior coverage.² The new insurer guaranteed no loss of benefits as a result of changing carriers.

The change was implemented by the District agreeing to a contract with Blue Shield. In October 1980, rumors spread among certificated employees that the District was contemplating the change. On October 28, Association President Scott Wiseman wrote to Superintendent Harry Roberts seeking clarification of the rumor. Wiseman stated that the Association believed the coverage by Blue Cross to be mandated by the terms of the recently expired contract and should continue in effect until a successor contract was negotiated. The District notified affected employees on November 4 that they could either switch to Blue Shield or waive insurance coverage.

While the District notified a District employee insurance study group on October 31, that it intended to change carriers, it did not notify the Association directly of its decision prior to taking action.

NEGOTIATIONS HISTORY

The parties operated under three collective bargaining agreements between January 1977 and June 30, 1980. Employees were working without a contract when the change in carriers occurred on November 1, 1980. The negotiation history and language of the three contracts is significant to determine whether the District had agreed to provide insurance specifically from Blue Cross or only to provide a specified level of benefits.

1977-78 Contract

The parties initial agreement under the EERA existed between January 1977 and June 30, 1978. During negotiations, the parties discussed both the identity of the insurance carrier and the district level of contribution. The contract required the district to pay for health and dental insurance up to a specified dollar amount. It did not mention Blue Cross and specifically authorized the District to select the insurance carrier.

Article 16. Salary and Benefits

4. (a) . . . the District shall retain the right to select the insurance carrier.

1978-79 Contract

The parties held several negotiation sessions during the spring and summer of 1978. The passage of Proposition 13 in June 1978 left the status of school financing uncertain. No discussion of salary or fringe benefits was included in the sessions.

The 1977-78 contract expired in mid-summer without an enactment of a successor contract. During a September 5, 1978 session District negotiator David Miller presented a verbal offer that the District would continue "Blue Cross" coverage in the new contract. An article on salaries and benefits was developed out of the September 5 meeting. The language for the article was drafted during the mediation session. The article extended health and dental coverage to family members and provided employee vision coverage. It specifically listed "Blue Cross" as the health insurance carrier.

Article 14 Salary and Benefits provided in part:

2. Up to \$104.34 tenthly for Blue Cross family coverage.

The contract was adopted on December 11, 1978 and was effective until June 30, 1979.

1979-80 Contract

The parties started negotiating in March 1979 for a new contract. On June 5, 1979 they extended

the 1978-79 contract through June 30, 1980 with the understanding that 1979-80 benefit levels would be revised through negotiations as soon as updated insurance date was available. Article 14.2 of the June 5th agreement contained identical language on insurance plans to the 1978-79 contract except that the District increased its contribution by approximately \$40 per year.

On September 19, 1979, the parties met to negotiate fringe benefits. District Superintendent Roberts presented a draft proposal. The proposal stated:

(1) Amend article section 14.2 to read: effective for the 1979/80 school year, the District agrees to pay the full payment of premiums for group medical, dental, and vision insurance plans *without reduction of benefits*.

(2) The Association agrees *to continue in an advisory capacity*, the cooperative study of alternative benefit plans in an effort to reduce the total premium cost of package without a reduction in benefits.

(3) The Association agrees to consider an increase in the deductible for the family health plan . . . in the event that a lower premium package is not available. (Emphasis added.)

Sometime after June 5, 1979, the District prepared the 1979-80 contract incorporating the 1978-79 contract with minor changes. The changes included four appendices listing various salary schedules and specific insurance benefits. Appendix C specified the health care coverages provided by the Blue Cross basic plan. The contract including the appendices was distributed to all certificated employees. After the September 19 amendment, the salary and fringe benefit article was attached to the prior contract package and made available to employees.

In sum, the agreement in effect prior to the District change in carriers consisted of (1) the text of the 1978-79 contract with minor language and substantive changes extending through 1980, (2) appendices to the 1979-80 contract describing Blue Cross fringe benefits, and (3) the insurance and the fringe benefit amendment executed on September 19, 1979. The parties dispute both the purpose of the September 19 session on fringe benefits and the meaning of the contract amendment which resulted from negotiations.

Association Interpretation

At the session the Association spokesman attempted to have Blue Cross named in the amendment but the superintendent opposed changing the language of the typed draft. No District representative explained the District's intended meaning of the draft at the session. The Association did not further pursue adding Blue Cross to the draft because it believed that the amendment was a continuation of the 1979-80 contract which included Blue Cross because the draft was being attached to that contract. Joyce Stinson, association president, also testified that their belief was based upon the fact that a specific waiver had been included in the 1977 agreement and no such language was present in the draft.

Finally, the Association believed the amendment was not an attempt to change carriers because the Blue Cross policy expired within 10 days and all parties agreed it was practically too late to change that year.

Stinson testified that the Association believed paragraph 1 to mean that the District would continue with the present coverage and specific carriers for medical, dental, and vision insurance and would pick up the increase in payments. She testified that the Association believed the language, "The District agrees to pay the full payment of premiums for group medical . . . plan without reduction of benefits," to mean a commitment to retain Blue Cross specifically because Blue Cross was a well known insurance carrier, i.e. a benefit.

The Association construed paragraph 2, "the Association agrees to continue in an advisory capacity . . . " as not waiving the District's obligation to bargain over the final selection of carriers. The belief was on the basis that the employee insurance committee was to include

classified employees and management employees in an advisory capacity and was not a substitute for bargaining.

The Association interpreted paragraph 3 not to constitute a waiver, including the language, "The Association agrees to consider an increase in the deductible . . . in the event that a lower premium package is not available." They considered that both parties would look at other insurance carriers and if a joint decision could not be reached the Association would consider a reduction in the current Blue Cross package.

District Interpretation

It is the District's position that the amendment to section 14.2 was a substitute for the similar section in the 1979-80 contract. In effect the amendment removed the specific reference to Blue Cross and authorized the District to name the insurance carrier.

Superintendent Roberts testified that paragraph 1 reflects the District prerogative to select insurance carriers as long as it did not reduce the benefits that would be provided. The District obligation to pick up the total premium for the first time was interrelated to the District's authority to reduce costs by selecting a less expensive carrier providing the same benefits. Superintendent Roberts testified that he didn't believe that the District's increased contribution under paragraph 1 was a trade off for the right to select an insurance carrier because he believed the District always had the right under prior contracts even though the carrier was named.

1980 Negotiations

The existing contract expired on June 30, 1980. The District made an initial proposal to change from Blue Cross to Blue Shield. The parties discussed the designation of health insurance carrier during negotiation sessions. The record is somewhat confusing over whether the District was intending to discuss the carrier or the level of benefits in that the term Blue Cross was used synonymously with the current level of benefits provided to employees.

The Association negotiator David Bates stated during negotiations that the Association would not object to changing the insurance carrier so long as the benefits were equal or better than those provided by Blue Cross. No tentative agreement was executed. It is apparent that Bates' statement was meant to result in a future agreement as a result of negotiations. The Association did not construe it as an agreement at the time because they were currently studying proposals by competing insurance carriers.

The District made alternative salary and fringe benefit offers. It expected to save \$15,000 for 1980-81 if a change to Blue Shield occurred. The District offered a Blue Shield health plan combined with a 7 percent salary increase for teachers or the existing Blue Cross plan combined with a 6 percent salary increase. The Association proposed a continuation of Blue Cross combined with a higher salary increase than offered by the District.

During September 1980, District Negotiator Ronald Ruud indicated that the District believed the prior contract gave it authority to unilaterally name the carrier.

Insurance Advisory Committee/Unilateral Change

No contract agreement had been reached by November 1980. During the spring of 1980, the District formed an advisory study group including classified employees, Association members, and management employees to study the new Blue Shield proposal. The change to Blue Shield was made by the District before the committee made any recommendation.

At an October 31 meeting of the committee, the superintendent implied that the District would be changing to Blue Cross effective November 1. On November 4, the District corresponded with employees that unless they authorized a change to Blue Shield immediately they would waive insurance coverage. No notice was given to the Association.

ISSUES

1. Did the District unilaterally change the carrier of health insurance for its employees in violation

of Government Code section 3543.5(a), (b), (c) and (e)?

2. Was the unilateral change authorized by the collective bargaining agreement or by waiver of the Association?

DISCUSSION AND CONCLUSIONS

It is well-settled under PERB precedent that an employer, absent compelling justification, cannot change matters within the scope of representation without providing the exclusive representative of the employees affected by the change with notice and an opportunity to negotiate. *San Francisco Community College District* (10/12/79) PERB Decision No. 105; *San Mateo County Community College District* (6/8/79) PERB Decision No. 94; *Pajaro Valley Unified School District* (5/22/78) PERB Decision No. 51; *NLRB v. Katz* (1962) 369 U.S. 736 [50 LRRM 2177]. In November, 1980 the District unilaterally changed from a Blue Cross health insurance plan to a Blue Shield plan. While the District had discussed or negotiated insurance benefits with the Association during the summer and fall of 1980, the change in carriers was not a result of negotiations.

The questions in this case are (1) whether the District's action in changing health plan carriers resulted in a change in a matter within the scope of representation under section 3543.2 and (2) whether such change was authorized by the collective bargaining agreement or other waiver of the Association.

Did the Change in Health Insurance Plans Fall Within the Scope of Representation

The District's change in health insurance plans is within scope because: (1) actual health benefits under the former plan were changed; (2) the reputation of the insurer and/or provider offering the plan is directly linked to health benefits; and (3) a change in group insurance plans directly impacts employee compensation.

Section 3543.2 of EERA provides:

The scope of representation shall be limited to matters relating to wages, hours of employment and other terms and conditions of employment. "Terms and conditions of employment" mean health and welfare benefits as defined by section 53200 . . .

It is apparent that health insurance benefits fall within the scope of representation.

In *Oakland Unified School District v. PERB* (1981) 120 Cal.App.3rd 1007, p. 1012; [175 Cal.Rptr. 105] the Court of Appeal found that a change in health insurance administrators which had a "material and significant effect or impact upon the terms and conditions of employment" was within the scope of negotiations. The Court upheld a PERB finding that the change in administrators resulted in a reduction of health insurance benefits to employees because certain benefits were inherently linked to the national identity of the former administrator - Blue Cross. In the present case, the District accurately alleges that the change in health plan resulted in a significant improvement in health insurance benefits to employees. Health insurance coverage was improved because employee paid deductibles were reduced in 11 areas of medical treatment or service.³

The threshold question is not whether the employer increased benefits or decreased benefits for employees because both actions constitute changes in the existing conditions of employment. Here changes in benefits clearly occurred.

Thus the substantial increase in health benefits had a "material . . . effect on the terms and conditions of employment," *supra Oakland* so that the identity of the insurance carrier is negotiable whenever resulting benefits are substantially changed. See *Keystone Consolidated Industries v. NLRB* (7th Circuit 1979) 606 F2d 171 [102 LRRM 2664]; *Oil Workers (OCAW) v. NLRB* (DC Circuit 1976) 547 F2d 575 [92 LRRM 3059]; *Connecticut Light and Power Company v. NLRB* (2nd Circuit 1973) 476 F2nd 1079 [82 LRRM 3121]; *Bastian-Blessing v. NLRB* (6th

Circuit 1973) 474 F2nd 49 [82 LRRM 2689].

As a separate theory, it is reasonable to assume that employees have a vital interest in knowing that their health care will be provided in a quality manner and their claims will be processed in a timely fashion. The identity and reputation of the insurer, administrator and health care provider becomes as significant as the coverage negotiated. Thus the health care plan becomes a condition of employment closely related to health benefits.

Finally, a fringe benefit such as paid insurance is actually a form of compensation. In the public school setting the employer's unilateral decision to increase fringe benefits necessarily impacts on the amount of money available for negotiating wages. A change in group insurance plans might hypothetically cost the employer (1) more, (2) an equal amount, (3) or less than its subsidy of the prior plan. Expenditure of either more or less funds for the plan directly impacts on its ability to negotiate wages with employees. The fact that the District made differing salary offers contingent upon which the health plan was adopted supports the direct relationship between the subjects.

Alleged Waivers

The District alleges that the Association waived its right to object to the unilateral change by agreeing to contract language authorizing the action or waived its rights to object by its actions. In order to prove that the Association waived its right to negotiate, the District must show either clear and unmistakable contract language or demonstrate behavior waiving a reasonable opportunity to bargain over a decision not already firmly made by the employer. *San Mateo County Community College District* (6/8/79) PERB Decision No. 94; *Amador Valley Joint Union High School District* (10/2/78) PERB Decision No. 74; *Timken Roller Bearing Company v. NLRB* (6th Circuit 1963) 325 F2d 746 [54 LRRM 2785]; *NLRB v. Cone Mills* (4th Circuit 1967) 373 F2d 595, [64 LRRM 2536] citing the NLRB in *Caravelle Boat* (1977) 227 NLRB 162 [95 LRRM 1003, 1006].

PERB has stated, "the board and courts have repeatedly held that a waiver of bargaining rights by a union will not be lightly inferred, must be clearly and unequivocally conveyed." *Anaheim Union High School District* (3/26/82) PERB Decision No. 201.

The Association did not Waive its Right to Object by Contract

Where specific language of an agreement must be interpreted to determine if a waiver has occurred, contract law principles apply. California courts have repudiated the former "plain meaning" rules limiting interpretation to the face of the contract language when it appears to be clear. Currently even if the language is clear, evidence of circumstances is admissible if relevant to prove a meaning of which the contract language is reasonably susceptible. *Pacific Gas & Electric Company v. G. W. Thomas D & R Company* (1968) 69 Cal 2nd 33 [452 Pacific 2nd 641], Summary of California Evidence 2nd, Witkin, 1977 Supplement section 732A, page 320.]

Additionally acts of the parties subsequent to execution of a contract and before a controversy arises as to its effect may be looked at. *Supra*, Summary of California Evidence 2nd, Witkin, section 527, p. 449.

The District contends that the deletion of the name Blue Cross and the substitution of the term "group medical insurance plan without reduction of benefits" in the September 1979 amendment is clear language demonstrating waiver by the Association. It argues the language is bolstered by the Association's agreement to continue in an advisory capacity to study alternative health benefit plans. It is further conceded that the Association requested the inclusion of the name Blue Cross in the adopted language and the proposal was rejected by the District. In spite of this strong evidence it is found that the waiver language is neither "clear nor unmistakable" when the circumstances surrounding its adoption are considered.

The September 19th agreement was reached at a brief evening session. No negotiations had occurred for 100 days. The disputed language was contained in a typed draft prepared by the District. The District spokesperson, Superintendent Roberts, did not explain that the language was

intended to remove the Association's right to negotiate over carriers as existed in the 1978-79 contract. Roberts testified that he did not consider the District's payment of increased benefits in the proposal to be a tradeoff for the right to select carriers because he always thought the District had the right to select an insurance carrier. The Association testified that despite the refusal of the District to include Blue Cross in the language, it assumed from the term "without reduction of benefits" that the inherent benefit of a nationally known plan as Blue Cross was protected.

At the time the amendment was negotiated, the parties were not seriously discussing any change from Blue Cross because renewal of that policy was imminent. While the District had at various times discussed the increasing costs of Blue Cross and the need to review comparable plans, no information was presented at the negotiation session to indicate that the language contemplated an actual change. Recognizing that the authority to change is not synonymous with an actual change in carriers, it is nevertheless significant that the absence of an ability of the District to change policies at that time gave the Association no notice of the significance of the language.

An important issue is the effect of the single page amendment to the 79-80 contract executed on September 19. It is clear that the language of the amendment superseded article 14 relating to health and welfare benefits. Yet the 1979-80 agreement was circulated to employees with two distinct and conflicting types of attachments. First, the September 19 amendment which purportedly eliminated Blue Cross as the negotiated carrier. Secondly, Appendix C was attached which listed the specific coverages provided under the Blue Cross basic health service plan. Whether or not the inclusion of the Blue Cross coverages was an administrative error, it gave unit employees and the Association a reasonable belief that the September 19 amendment made no drastic change in the continuance of Blue Cross coverage. More importantly, it gave weight to the interpretation that the amendment did not make a substantive change in the right to select carriers. Finally, the District opened the 1980 negotiations by presenting a written proposal relating to the negotiation of insurance carriers. The identity of carriers was frequently raised during the subsequent negotiations. The District's subsequent conduct of negotiating the carrier weighs against a clear achievement of the right to select a carrier in the 1979-80 contract. The District's argument that it hoped to receive a consensus approval in the change in the selection of carriers although it retained the right to do so unilaterally is weakened by its actions in seeking to negotiate the subject after it had supposedly achieved the September 19th waiver. Only at a time when the District's legal advisor became its chief negotiator did it indicate at the table that it had achieved the right to change carriers through the previous negotiations.

The contract language indicating that the Association agrees to continue in an advisory capacity to study alternative health benefit plans is extremely difficult to interpret. The very words "an advisory capacity" imply the waiving of certain rights. Yet the Association's interpretation that a voluntary study was necessitated because it had no right to bargain over those aspects of a single plan which affected non-unit employees is plausible. Otherwise the District would be required to conduct separate investigations of health plans for certificated, classified, and management employees prior to negotiating with the former two groups.

Finally, the waiver language must be compared to the Association waiver agreed to in the 1977-78 contract. There the language specifically stated "the District shall retain the right to select the insurance carrier." With a history of such clear language between the parties on the same subject, the September 19 language is made less unequivocal. It is found that under the circumstances and absent any District communication of its intent, the language does not demonstrate a "clear and unmistakable waiver."

The Association did not Waive its Right by Action or Inaction

The District contends that David Bates made an oral agreement during the 1980 negotiations that the Association would accept Blue Shield if the benefits were equal to those provided by Blue Cross.

The evidence indicates that no tentative agreement was signed. In fact, no dispute exists that the statements were made by Bates. It is reasonable to believe that the Association's statements were solely to indicate that the Association would agree in the future provided they were assured that the change would create no loss in benefits. This assurance could come only after their own study of the proposed plan. The study was underway at the time although the Association was not provided with the frequent changes in the proposal offered by Blue Cross.

The record also fails to indicate that the Association delayed in objecting to the change in carriers upon receiving notice from the District. In October 1980, the Association president sought to verify rumors that a change was being considered even in the absence of District notice. Although the District unilaterally changed carriers in November 1980, it did not directly notify the Association any time prior to taking action. An Association demand to negotiate after the District has already taken the action is not required when such requests would be futile. *San Mateo County Community College District* (6/8/79) PERB Decision No. 94.

Derivative Violations

PERB has found that conduct violating section 3543.5(c) is concurrently a violation of section 3543.5(b) by denying the Association its statutory right as an exclusive representative to represent union members in their employment relations. It is further found the failure to meet and negotiate interferes with employees because of their exercise of representational rights in violation of section 3543.5(a). *San Francisco Community College District* (10/12/79) PERB Decision No. 105.

The Association's alleged violation of section 3543.5(e), is dismissed for lack of proof.

REMEDY

Section 3541.5(c) of the Act provides:

The Board shall have the power to issue a decision and order directing an offending party to cease and desist from the unfair practice and to take such affirmative action . . . as will affectuate the policies of this chapter.

In its closing brief the Association has indicated that subsequent to the hearing the parties have negotiated and reached agreement upon implementation of the Blue Shield health insurance plan. The remedy sought by the Association is limited to the issuance and posting of an appropriate cease and desist order. Therefore the appropriate remedy is a cease and desist order directed against the District. It is also appropriate to order the District to post the attached notice on appropriate bulletin boards incorporating the terms of the order. The notice should be subscribed by an authorized agent of the District indicating that it will comply with the terms thereof. The notice shall not be reduced in size. Posting will provide employees with notice that the District has acted in an unlawful manner and is being required to cease and desist from this activity. It effectuates the purposes of the EERA that employees be informed of the resolution of the controversy and announces the District's readiness to comply with the order of remedy. See *Placerville Union School District* (9/18/78) PERB Decision No. 69. In *Pandol and Sons v. ALRA and UFW* (1979) 98 Cal.App. 3rd 580, 587, the California District Court of Appeal approved a posting requirement. The U.S. Supreme Court approved a similar posting requirement in *NLRB v. Express Publishing Company* (1941) 312 U.S. 426 [8 LRRM 415].

PROPOSED ORDER

Upon the proposed foregoing findings of fact, conclusions of law and the entire record of this case, it is hereby ordered that the alleged violation of section 3543.5(e) is DISMISSED.

Upon the foregoing findings of fact, conclusions of law and the entire record of this case, and pursuant to Government Code section 3541.5(c) of the Educational Employment Relations Act, it is hereby ordered that the Palo Verde Unified School District, board of trustees, superintendent and their respective agents shall:

a. CEASE AND DESIST FROM:

- (1) Failing and refusing to meet and negotiate in good faith by making unilateral changes in the identity of the health insurance carrier for employees within the negotiating unit;
- (2) Denying to Palo Verde Teachers Association, CTA/NEA rights guaranteed by the Educational Employment Relations Act including the right to represent its members; and
- (3) Interfering with employees because of the exercise of rights guaranteed by the Educational Employment Relations Act.

b. TAKE THE FOLLOWING AFFIRMATIVE ACTION WHICH IS NECESSARY TO EFFECTUATE THE POLICIES OF THE EDUCATIONAL EMPLOYMENT RELATIONS ACT:

(1) Within seven (7) workdays after the date of service of a final decision in this matter, post at all work locations where notices to employees customarily are posted, copies of the notice attached as an appendix hereto, signed by an authorized agent of the employer. Such posting shall be maintained for a period of thirty (30) consecutive workdays. Reasonable steps shall be taken to ensure that the notices are not altered, reduced in size, defaced or covered with any other material;

(2) Within twenty (20) consecutive workdays from service of the final decision herein, notify the Los Angeles Regional Director of the Public Employment Relations Board in writing of what steps the employer has taken to comply with the terms of this decision. Continue to report in writing to the regional director thereafter as directed. The reports to the regional director shall be served concurrently on the charging party herein.

Pursuant to California Administrative Code, title 8, part III, section 32305, this Proposed Decision and Order shall become final on August 2, 1982, unless a party files a timely statement of exceptions. In accordance with the rules, the statement of exceptions should identify by page citation or exhibit number the portions of the record relied upon for such exceptions. See California Administrative Code, title 8, part III, section 32300. such statement of exceptions and supporting brief must be actually received by the executive assistant to the Board at the headquarters office of the Public Employment Relations Board in Sacramento before the close of business (5:00 p.m.) on August 2, 1982, in order to be timely filed. See California Administrative Code, title 8, part III, section 32135. Any statement of exceptions and supporting brief must be served concurrently with its filing upon each party to this proceeding. Proof of service shall be filed with the Board itself. See California Administrative Code, title 8, part III, section 32300 and 32305 as amended.

¹ The EERA is codified at Government Code section 3540 *et seq.* All references herein are to the Government Code unless otherwise noted.

² Improvement was made in coverages for the daily room rate, hospital miscellaneous expenses, intensive coverage care, skilled nursing facility benefits, surgical benefits, doctor visits, out-patient and x-ray benefits, psychiatric benefits, ambulance benefits, additional accident expense, major medical benefits, and stop loss. The Blue Cross policy features the indirect benefit of subrogation not allowed by Blue Shield. Subrogation is not found to be a significant benefit because the gain to a single employee by lawsuit results in a direct rate increase to other members of the District plan.

³ See footnote 2.
